

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change and addition of information on certificate is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 182

07848

No. G 97 AUG 31 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH:

County CalvertCity or town Breezy Point
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va County MarcusCity or town Bluefield
(If outside city or town limits, write RURAL and give nearest town)Street No. 1800 Vineland
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Robie Paul Allen

3. (b) Social Security Number

233-09-6020

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Josephine Grim

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

May 4, 1906

8. AGE:

39

Years

Months

3

Days

11

If less than one day

hrs.

min.

9. Birthplace W. Va., Bluefield

(Town, county, and state)

10. Usual occupation Radio Tech.Naval Air Station

11. Industry or business

12. Name Harmon Preston Allen

13. Birthplace

Virginia

MOTHER

14. Maiden name Bessie Lee Maney

15. Birthplace

Wytkeville, Va.16. Informant Mrs. Josephine AllenAddress 846 A. West 24th St., Norfolk, 8, Va.17. Burial
(Burial, cremation, or removal, Which?)Date thereof 8/16/45
(month) (day) (year)

Cemetery or crematory

Cemeter

Location

Int. Harmony

18. Funeral director

Wm. H. Hutchins

Address

Cummins road19. Aug 15 19 45
(Date read by registrar)Grace Hutchins
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/15 19 45 at 1200 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....

and that I last saw him alive on 19.....

Immediate cause of death

Wounded

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of ?

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Shovel

Injured at work?

23. SIGNATURE

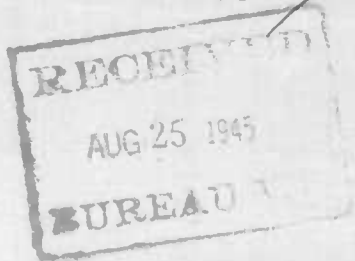
Harmon

M. D. or other

Address Living W. Va Date signed 8/15/45

RECEIVED
AUG 25 1945
BUREAU U.S.

This body washed ashore
and it was necessary to
bury it as soon as possible.
The information on this Certificate
is all the medical examiner
had.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of
name of town where death
occurred, is shown on
FILE NO. G 98 SEP 18 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

07849

★ Reg. Dist. No. 52

1. PLACE OF DEATH:

County Calvert
City or town Owings
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Joseph W. Fowler

4. Sex mn. 5. Color or race w 6. (a) Single, married, widowed, or divorced mn

6. (b) Name of husband or wife Lula G. Fowler

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 63 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name John W. Fowler

13. Birthplace Agona md

14. Maiden name Robert Ward

15. Birthplace md

16. Informant Herbert Fowler

Address Owings md

17. (Burial, cremation, or removal, Which?) Burial Date thereof 8/6/45
(month) (day) (year)

Cemetery or crematory Compton

Location Mt. Harpagon

18. Funeral director Wm. A. Dolephus

Address Owings md

19. Aug 5 19 45 Chas. P. Hulse
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Calvert

City or town Owings
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 Aug 19 45 at 12:30 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1 Aug 19 45 to 4 Aug 19 45

and that I last saw him alive on 3 Aug 19 45

Immediate cause of death Hypertensive crisis complicating atherosclerosis

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ injured at work?

23. SIGNATURE J. Hulse M. D. or other _____

Address Huntingtown Md. Date signed 4 Aug 45

RECEIVED

SEP 13 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12-6)

07850

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County Calvert
 City or town Prince Frederick Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Patricia Graves

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Feb 18, 1933

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

12

hrs. min.

9. Birthplace

D.C.

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Joseph Edward Graves

13. Birthplace

Maryland

14. Maiden name

Katherine J. Beck

15. Birthplace

D.C.

16. Informant

Address

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

Aug 8, 1945

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Wm. J. Walsh

Address

522-8th St. S.E. Wash. D.C.

19.

Aug 5, 1945

S. N. King

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

5 Aug 1945

at

7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3 Aug 1945

to 5 Aug 1945

and that I last saw him alive on

5 Aug 1945

Immediate cause of death

Intestinal obstruction

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Intestinal obstruction

Date of op. Aug 45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

S. N. King

M. D. or other

Address

S. N. King

Date signed

RECEIVED
AUG 9 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07851

Reg. Dist. No. 51

1. PLACE OF DEATH:

County CabnetCity or town Prince Frederick, Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Cabnet County Hospital

How long in hospital or institution?

3. (a) FULL NAME

Lida Priscilla Gores

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife

George R. Gores

7. Birth date of deceased (mo., day, yr.)

Mar. 9, 1880

8. AGE:

Years

Months

Days

If less than one day

65

5

18

hrs.

min.

9. Birthplace

Cabnet County, Md

10. Usual occupation

None

11. Industry or business

Abraham Monnett

12. Name

13. Birthplace

Cabnet Co., Md

14. Maiden name

Priscilla Gores

15. Birthplace

Cabnet County, Md

16. Informant

George R. Gores

Address

Bushy, Md

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Middlebrook Chapel

Location

Bushy, Md

18. Funeral director

G. A. Harkness & Son

Address

Mutual, Md19. 8/28

(Date rec'd by registrar)

19 45

- N. King

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County CabnetCity or town Bushy
(If outside city or town limits, write RURAL and give nearest town)Street No. 7
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 19 45 at 3a M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 19 45 to Aug 27 19 45and that I last saw him alive on 8-27-45 19 45Immediate cause of death CoughDue to Ca of liverDue to Ca of liverOther conditions - Anterior of liver

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Page J. StAddress Prince FrederickDate signed 8/27/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 1 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-2

CERTIFICATE OF DEATH

07852

52

Reg. Dist. No.

1. PLACE OF DEATH:

County... *Calvert*City or town... *Quinn's*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *md* County... *Calvert*City or town... *Quinn's*
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

Charles Thomas Howard

3. (b) Social Security Number

4. Sex

m

5. Color or race

w

6. (a) Single, married, widowed, or divorced

m.

8. (b) Name of husband or wife...

Agnes Catherine

6. (c) If alive, give age... years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

67

Years

Months

Days

It less than one day

hrs.

min.

9. Birthplace...

Lower Marlboro Md
(Town, county, and state)

10. Usual occupation...

Farmer

11. Industry or business

FATHER
MOTHER

12. Name...

John B. Howard

13. Birthplace

md

14. Maiden name

Charlotte Ann.

15. Birthplace

md.

16. Informant...

Charles Howard

Address

Quinn's md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Aug 8 45
(month) (day) (year)

Cemetery or crematory

Mt. Zion Cemetery

Location

Mt. Zion, Md.

18. Funeral director

W. H. Hutchins

Address

Quinn's, Md.

19.

(Date rec'd by registrar)

19

*45**Grace Hutchins*

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 6

19

45-4-55

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2 Mar

19

45

to

4 Aug

19

45

and that I last saw him alive on

4 Aug

19

45

Immediate cause of death

metastatic carcinoma

DURATION

Due to

carcinoma of foot

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Grace Hutchins

M. D. or other

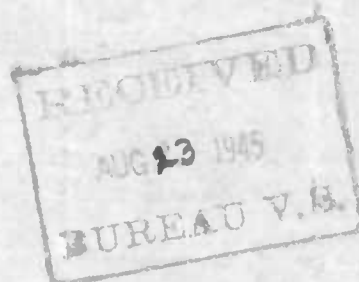
45

Address

Quinn's

Date signed

7 Aug



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County... *Calvert Co.*City or town... *Prince Frederick*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?... *6 hours*

Hospital, institution, or street address where death occurred:

Calvert Co. Hosp.

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *MD.* County... *Prince George's*City or town...
(If outside city or town limits, write RURAL and give nearest town)Street No...
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Balry Girl Jefferson

3. (b) Social Security Number

4. Sex

F

5. Color or race

B

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *8/4/45* 6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

6 hrs. *15* min.9. Birthplace... *Prince Frederick*
(Town, county, and estate)

10. Usual occupation.....

11. Industry or business.....

12. Name... *Carl Jefferson*13. Birthplace... *Lucy, Calvert Co. MD.*14. Maiden name... *Madame Thomas*15. Birthplace... *Calvert Co. MD.*16. Informant... *Carl Jefferson*Address... *Lucy, MD.*17. *Burial* Date thereof... *8-4-45*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location... *Lucy, Md.*18. Funeral director... *Carl Jefferson*Address... *Lucy, Md.*19. *8-4* 19 *45* *J. H. King*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... *August 4* 19 *45* at *6:30 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 4 19 *45* 10..... 19.....and that I last saw him alive on *August 4* 19 *45*

Immediate cause of death.....

Premature - (6 months)

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE... *Dr. J. H. King* M. D. or otherAddress... *Prince Frederick* Date signed *8/4/45*

RECEIVED
AUG 9 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

07854

★ Reg. Dist. No. 52

1. PLACE OF DEATH:

County CalvertCity or town H. Beach
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Dist. Wash. County Calvert DCCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Gus Tsimbias

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 18948. AGE: Years 51 Months 6 Days 9 If less than one day _____ hrs. _____ min.9. Birthplace Greece
(Town, county, and state)10. Usual occupation Waiter in Hotel

11. Industry or business _____

FATHER

12. Name _____

13. Birthplace Unknown

MOTHER

14. Maiden name _____

15. Birthplace _____

16. Informant Mrs. Max R. SteinerAddress 712 Erie Ave. Tacoma Park17. Burial, cremation, or removal, Which? Burial Date thereof Aug. 27/45
(month) (day) (year)Cemetery or crematory CemeteryLocation Arlington, Va.18. Funeral director W. H. HutchinsAddress Owings, Md.19. Aug. 24, 45 Grace R. Hutchins
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/23 19 45 at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____

and that I last saw h. live on _____ 19 _____Immediate cause of death Coronaryarteriosclerosis

DURATION

2 min

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE H. R. V. V. V.

M. D. or other _____

Address Spring 1945 Date signed _____

RECEIVED
SEP 13 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 07855 52

1. PLACE OF DEATH:

County CalvertCity or town Dumburke
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County CalvertCity or town _____
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Clarence E. Whittington

3. (b) Social Security Number

4. Sex m 5. Color or race w 6.(a) Single, married, widowed, or divorced m6.(b) Name of husband or wife Fred P. Whittington7. Birth date of deceased (mo., day, yr.) April 20, 1880 6.(c) If alive, give age _____ years8. AGE: Years 65 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Calvert Co md
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business _____

12. Name Robert E. Whittington13. Birthplace md14. Maiden name Emma Childs15. Birthplace md16. Informant Mr Raymond WhittingtonAddress Dumburke md17. (Burial, cremation, or removal. Which?) Burial Date thereof 8/31/45
(month) (day) (year)Cemetery or crematory CemeteryLocation Smithville18. Funeral director Wm H. HutchinsAddress Quincy md19. Aug 30 19 45 Grace Hutchins
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 19 45 at 8:30 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 28 19 45 to _____ 19 _____and that I last saw him alive on August 29 19 45Immediate cause of death Cerebral Hemorrhage

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Grace Hutchins M. D. or otherAddress Quincy md Date signed 8/29/45

UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

SEP 13 1945

BUREAU V.B.